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# HOW MFN CLAUSES USED IN THE HEALTH CARE INDUSTRY UNREASONABLY RESTRAIN TRADE UNDER THE SHERMAN ACT

BETH ANN WRIGHT<sup>1</sup>

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### *Abstract*

When used in the health care industry, an MFN clause is a contractual agreement that guarantees a health insurer the same best price as their market competitors. MFN clauses have the effect of unnecessarily raising consumer costs, reducing choice among providers, constraining access to care and preventing the development of alternative health care delivery models. The purpose of this paper is four-fold. First, to design a four-quadrant matrix to evaluate the pro-competitive and anticompetitive purposes and effects of MFN clauses under Section 1 of the Sherman Act. Second, to defeat the jurisprudential presumption that MFN clauses are pro-competitive in the health care industry and to recommend that this presumption be abolished. Third, to examine the U. S. Department of Justice's paradigmatic shift over the last decade toward prosecuting large insurers who employ MFN clauses resulting in U.S. Consent Decrees. Fourth, to outline the indicia of a meritorious claim against an insurer who employs an MFN clause.

### INTRODUCTION

A most favored nations (MFN) clause is a contractual agreement between a buyer and a seller stating that the price paid by the buyer will be at least as low as the price paid by other buyers who purchase the same commodities from the seller.<sup>2</sup> In health care, the contract is typically between the health insurer who acts as the purchaser of health care services on behalf of its subscribers and the medical provider who acts as the seller of health care services.<sup>3</sup> MFN clauses have also been dubbed prudent

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<sup>2</sup>Arnold Celnicker, A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers, 69 N.C. L. REV. 863 (1991).

<sup>3</sup>Anthony Dennis, Most Favored Nation Contract Clauses Under the Antitrust Laws, 20 U. DAYTON L. REV. 821, 823 (1995) [hereinafter Dennis, Most Favored Nation Contract Clauses].

buyer clauses,<sup>4</sup> price nondiscrimination clauses,<sup>5</sup> usual fee-provisions,<sup>6</sup> and most favored rate requirements.<sup>7</sup>

Only a health insurer with sufficient market power can negotiate the incorporation of an MFN clause in consideration for the exchange of a relatively large volume of business in the relevant market.<sup>8</sup> Typically, only one health insurer per market will secure provider contracts incorporating the MFN clause. As an insurer with sufficient market power, Blue Cross and Blue Shield plans started using MFN clauses in contracts with providers as a way to maintain market strength in the face of the emerging alternative health care delivery models like HMOs and PPOs.<sup>9</sup> The U.S. Government, corporations offering employer-based health insurance, and American citizens as consumers, all have reason for serious concern regarding the anticompetitive nature of MFN clauses. These clauses have the effect of unnecessarily raising consumer costs, reducing choice among providers, constraining access to care, and preventing the development of alternative health care delivery models.

The purpose of this paper is four-fold. First, to design a four-quadrant matrix to evaluate the pro-competitive and anticompetitive purposes and effects of MFN clauses under the “rule of reason” standard of review where a violation of Section 1 of the Sherman Act is alleged. Second, to defeat the jurisprudential presumption that MFN clauses are pro-competitive in the health care industry and recommend that the presumption be abolished in health care cases. Third, to examine the U. S. Department of Justice’s paradigmatic shift over the last decade toward prosecuting large insurers who employ MFN clauses resulting in U.S. Consent Decrees for Sherman Act Section 1 violations. Fourth, to outline the indicia of a meritorious claim against an insurer who employs an MFN clause in an agreement with medical providers.

## I. THE SHERMAN ACT

Most complaints alleging antitrust violations involving MFN clauses are brought under Sections 1 and 2 of the Sherman Act. Section 1 claims are either examined under the per se rule or the rule of reason. The court decides which rule to use on a case-by-case basis, applying the facts of the case to guiding precedent. First, the court examines the language of the Sherman Act and how courts have interpreted and applied it. Second, a Sherman Act Section 1 violation where the court applies

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<sup>4</sup>*Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I.*, 883 F.2d 1101 (1st Cir. 1989).

<sup>5</sup>*Blue Cross and Blue Shield of Mich. v. Michigan Ass’n of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980); *Michigan Ass’n of Psychotherapy Clinics v. Blue Cross and Blue Shield of Mich.*, 118 Mich. App. 505, 325 N.W.2d 471 (1982).

<sup>6</sup>*Madden v. California Dental Serv.*, 1986-1 Trade Cas. (CCH) ¶ 67, 176 (Cal. Super. Ct. 1986).

<sup>7</sup>*United States v. Medical Mut. of Ohio*, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio, E. Div.).

<sup>8</sup>Dennis, *Most Favored Nation Contract Clauses*, *supra* note 3, at 823.

<sup>9</sup>*Id.* at 823; & n.14.

the rule of reason is more meritorious because the MFN clause can produce anticompetitive effects which unreasonably restrain trade through a contract, combination, or conspiracy. Third, the court's reasoning in *Ocean State*, where the plaintiff failed on the merits to establish an unlawful monopoly under Section 2 of the Act highlights an important distinction between Section 1 versus Section 2 claims.

First, regarding Section 1 violations, the Sherman Act states that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."<sup>10</sup> Because any agreement concerning trade can restrain competition, the Supreme Court has interpreted Section 1 to "render unlawful only those restraints that unreasonably restrict competition."<sup>11</sup>

Whether an agreement unreasonably restrains trade is traditionally analyzed under either the per se rule or the rule of reason standard of review. If a "practice facially appears to be one that would always or almost always tend to restrict competition and decrease output" rather than "one designed to 'increase economic efficiency and render markets more, rather than less, competitive,'" it is deemed "per se illegal."<sup>12</sup> The per se rule disregards the defendant's market power, illicit purpose, and the anticompetitive effects of the agreement.<sup>13</sup> Application of the per se rule as the standard of review is generally limited to claims involving horizontal price-fixing or market allocation agreements among competitors.<sup>14</sup> Generally, all other Section 1 claims are reviewed under the rule of reason.

The *Delta Dental* court articulated a rationale for applying the rule of reason to a Section 1 claim as opposed to the per se rule. In *Delta Dental*, the thrust of the government's complaint centered on the anticompetitive effect on price to the market as a whole, realized through market foreclosure of reduced fee plans by new market entrants, the inability of existing plans to offer lower fee alternatives, and the maintenance or increase in consumer prices.<sup>15</sup> The court reasoned that applying the per se rule to these allegations would "contradict the Sherman Act's animating concern of protecting consumers from high prices."<sup>16</sup> Rather, the court only conducts a balancing test, where it weighs the anticompetitive effects of the agreements against their legitimate business justifications (i.e. pro-competitive purposes and effects) under the rule of reason.<sup>17</sup>

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<sup>10</sup>Sherman Act, 15 U.S.C. § 1.

<sup>11</sup>United States v. Delta Dental of R. I., 943 F. Supp. 172 (D.R.I. 1996).

<sup>12</sup>Broadcast Music, Inc. v. CBS, 441 U.S. 1, 19-20, 99 S. Ct. 1551, 1562-63, 60 L.Ed.2d 1 (1979).

<sup>13</sup>*Delta Dental*, 943 F. Supp. at 186 (citing U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 593 (1st Cir. 1993)).

<sup>14</sup>*Delta Dental*, 943 F.Supp. at 186.

<sup>15</sup>*Id.* at 191.

<sup>16</sup>*Id.*

<sup>17</sup>*Id.*

Under the rule of reason, this balancing test determines whether the plaintiff has met his burden of proof that the “anticompetitive effects of the agreements outweigh their legitimate business justifications.”<sup>18</sup> The inquiry focuses on whether the restraint on competition impacts the market as a whole.<sup>19</sup> As such, an agreement is not an unreasonable restraint on trade merely because it injures a competitor.<sup>20</sup> Rather, the agreement becomes an unreasonable restraint only when it “causes detriment to the competitive process” on the market as a whole.<sup>21</sup> Therefore, only unreasonable restraints on trade which affect the market generally are prohibited under the rule of reason.

While a court will hear a Sherman Act Section 1 claim alleging anticompetitive purposes and/or anticompetitive effects, prevailing appears more likely when the evidence shows sufficient anticompetitive effects. The primary reason prevailing on the merits improves where anticompetitive effects are shown lies in the balancing test employed by the courts under the rule of reason. The pro-competitive purposes and effects are weighed against the anticompetitive purposes and effects. If the anticompetitive effects, therefore, are not yet recognized in the market, then only the anti competitive purpose weighs in the balance. It follows that the plaintiff who can prove actual anticompetitive effects caused by the competitor’s MFN clause possesses a greater likelihood of succeeding on the merits, as opposed to a plaintiff alleging mere anticompetitive purposes. Put differently, actual negative anticompetitive effects must be felt by the market as a whole for the plaintiff to tip the balance and overcome the presumption of pro-competitive conduct.<sup>22</sup>

Second, regarding Section 2 violations, the First Circuit in *Ocean State* stated that the monopolization claim under the Sherman Act Section 2 requires: “(1) the possession of monopoly power in the relevant market, and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.”<sup>23</sup> While

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<sup>18</sup>*Id.* at 186 (citing *Monahan’s Marine, Inc. v. Boston Whaler Inc.*, 866 F.2d 525, 526-27 (1st Cir. 1989)).

<sup>19</sup>*Delta Dental*, 943 F. Supp. at 186 (citing *Nat’l Soc’y of Prof’l Eng’rs v. United States*, 435 U.S. 679, 691 n.17, 98 S. Ct. 1355, 1365 n.17, 55 L.Ed.2d 637 (1978)).

<sup>20</sup>*Id.* at 186 (citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 319-20, 82 S. Ct. 1502, 1521, 8 L.Ed.2d 510 (1962)).

<sup>21</sup>*Id.* at 186 (citing *Clamp-All Corp. v. Cast Iron Soil Pipe Inst.*, 851 F.2d 478, 486 (1st Cir. 1988)).

<sup>22</sup>The U.S. Government has entered into five separate consent decrees with defendants who used MFN clauses, or their equivalent, where actual anticompetitive effects were in evidence. *See* Consent Decrees: *United States v. Delta Dental of R. I.*, 1997-2 Trade Cas. (CCH) ¶ 71,860 (D.R.I. 1997); *United States v. Medical Mut. of Ohio*, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio, E. Div.); *United States v. Vision Serv. Plan*, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996); *United States v. Oregon Dental Serv.*, 1995-2 Trade Cas. (CCH) ¶ 71,062 (D. Or. 1995); *United States v. Delta Dental Plan of Ariz.*, 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995).

<sup>23</sup>*Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I.*, 883 F.2d 1101, 1110 (1st Cir. 1989), *cert. den.*, 110 S. Ct. 1473 (1990) (quoting *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966)).

an MFN clause may eliminate competition to the degree that the dominant insurer has effectively created a monopsony, the Section 2 inquiry fails to examine the most salient features of the MFN clause's effect on competition. The operation of the MFN clause on market competition better fits with Section 1 analysis where the MFN clause may operate to unreasonably restrain trade with anticompetitive effects on the market as a whole through a contract, combination, or conspiracy. Moreover, the Antitrust Division of the U.S. Government has entered five separate U.S. Consent Decrees subsequent to filing a complaint alleging Sherman Act Section 1 violations as opposed to Section 2 violations.<sup>24</sup>

Third, although *Ocean State* primarily involves a Sherman Act Section 2 challenge, the court's reasoning is instructive on several points because the *Ocean State* clause is identical to *Delta Dental's* MFN clause.<sup>25</sup> The *Ocean State* court observed that Section 2 prohibits "'exclusionary' conduct by a monopoly, often defined as 'behavior that not only (1) tends to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way.'"<sup>26</sup> The court concluded that the MFN clause "was a bona fide policy to ensure that Blue Cross would not pay more than any competitor for the same services."<sup>27</sup> The First Circuit in *Ocean State* stated that "the MFN clause's insistence on a supplier's lowest price, absent pricing that is either predatory or below the supplier's incremental cost, 'tends to further competition on the merits and as a matter of law, is not exclusionary.'"<sup>28</sup>

*Ocean State* loses on their Section 2 claim against Blue Cross alleging an unlawful monopsony on judgment. In contrast, the United States survives *Delta Dental's* motion to dismiss its Section 1 claim; *Delta Dental* subsequently enters a U.S. Consent Decree agreement.<sup>29</sup> Therefore, framing the issue as a Section 2 claim requires the plaintiff who is challenging an MFN clause to prove too much. Excluding competitors from the market place through monopolization under Section 2 is a much higher evidentiary threshold to meet and is different in character from proving an unlawful restraint on trade through contract, combination, or conspiracy.

Therefore, in alleging a Sherman Act Section 1 claim where the court applies the rule of reason, the antitrust plaintiff who can prove actual anticompetitive effects caused by the competitor's MFN clause, possesses a greater likelihood of succeeding on the merits, as opposed to a plaintiff who alleges a Section 2 monopsony claim. While an antitrust plaintiff challenging an MFN clause may under some circumstances be able to prove a Section 2 claim, and therefore assert both allegations as separate kinds of unlawful conduct, further discussion of Section 2 claims is beyond the scope of this paper.

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<sup>24</sup>See *supra* note 22.

<sup>25</sup>*Delta Dental*, 943 F. Supp. at 187.

<sup>26</sup>*Id.* at 188.

<sup>27</sup>*Id.*

<sup>28</sup>*Id.*

<sup>29</sup>*United States v. Delta Dental of R. I.*, 1997-2 Trade Cas. (CCH) ¶ 71,860 (D.R.I. 1997).

## II. THE BALANCING TEST UNDER THE RULE OF REASON

Under a Sherman Act Section 1 claim where the court applies the rule of reason, the court will weigh all of the evidence the parties present regarding the MFN clause's pro-competitive purposes, pro-competitive effects, anticompetitive purposes, and anticompetitive effects. A four-quadrant matrix is designed to aid in analyzing and evaluating the merits of a Sherman Act Section 1 violation.<sup>30</sup> This paper examines case law, economic principles, and entertains new insights regarding the competitive nature of MFN clauses in health care.

### A. Quadrant I: Pro-competitive Purposes

#### 1. Guard Against Discriminatory Pricing

First, an insurer with sufficient bargaining power uses an MFN clause to guard against discriminatory pricing in the market, effectively promoting competition.<sup>31</sup> A narrow price differential among competitors in the marketplace may facilitate competition in other aspects of the product or service. In the health care industry, access to care, the number and location of physicians in the panel, wellness and holistic medicine alternatives, hassle-free payment of medical claims, case management, and overall quality of care arguably may gain importance in the market when the range in the price paid to medical providers is narrow. Therefore, by clustering prices, the MFN clause may stimulate market competition in product design and service delivery.

#### 2. Tool to Secure Volume Discounts

Second, MFN clauses are just the tool used in the industry to secure the favorably low price typically granted to the large buyer as a volume discount.<sup>32</sup> Judge Posner in the *Marshfield Clinic* case calls MFN clauses "standard devices" buyers use to bargain for low prices by requiring the seller to treat them as any other buyer.<sup>33</sup> Therefore, using an MFN clause to guard against discriminatory pricing and to

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<sup>30</sup>See Table 1.

<sup>31</sup>See Susan E. Stenger, Most-Favored-Nation Clauses and Monopsonistic Power: An Unhealthy Mix?, 15 AM. J.L. & MED. 111, 115 (1989).

<sup>32</sup>Anthony J. Dennis, Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts, 4 ANNALS HEALTH L. 71 (1995) [hereinafter Dennis, Potential Anticompetitive Effects].

<sup>33</sup>*Blue Cross and Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995). CompCare, the Blue Cross HMO subsidiary, alleged collusion and price-fixing between Marshfield Clinic and her affiliated physicians. CompCare argued that the *Clinic* had an agreement under which the Clinic would not pay the affiliated physicians more than what these physicians charge their other patients. CompCare argued that this agreement "put a floor underneath these physicians' prices." The physician affiliates were penalized for accepting lower prices from other patients because the Clinic rate automatically declined to the lowest price offered to any competitor. Justice Posner called this most favored nation clause argument "ingenious but perverse." He acknowledged the Department of Justice's position that these clauses are "misused to anticompetitive ends" in some cases, but maintains no such evidence exists in this case.



secure favorable prices as a volume discount has been viewed by courts to fulfill pro-competitive purposes.

*B. Quadrant III: Pro-competitive Effects*

Two potentially pro-competitive effects of MFN clauses are lower prices overall because discounts will be given to all buyers and a guarantee to buyers that they are receiving the same best price.<sup>34</sup>

1. Lower Prices Overall

The *Kartell* court considered the fact that the prices at issue were low prices, not high prices. The First Circuit declared that “the Congress that enacted the Sherman Act saw it as a way of protecting consumers against prices that were too *high*, not too low.”<sup>35</sup> Therefore, the pro-competitive effect of lowering prices to a point which is not so low as to constitute predatory pricing presumptively benefits the buyer and stimulates price competition in the market.

2. Guarantee the Same Best Price

The First Circuit echoed the principle again in *Ocean State* concluding that the buyer’s insistence on a supplier’s lowest price through the use of an MFN clause, absent predatory pricing, “tends to further competition on the merits and, as a matter of law, is not exclusionary.”<sup>36</sup> Therefore, if the MFN clause operates to lower prices to consumers, then a court may find that this pro-competitive effect is a reasonable restraint on trade because it benefits consumers.

*C. Quadrant II: Anticompetitive Purposes*

The MFN clause can exert anticompetitive purposes which create an artificial price floor for medical services and establish price certainty in the market. The device can, in effect, harm the market by unnecessarily increasing competitor’s costs for similar products and services. If an artificial price floor and price certainty actually results in higher prices to consumers, then the MFN device can be viewed as an anticompetitive method to restrain trade to the detriment of consumers.

1. Creating an Artificial Price Floor

The insurer who imposes the MFN clause possesses market power and intends to maintain or increase their market dominance.<sup>37</sup> The MFN clause can create an artificial price floor that the MFN insurer regulates. Because the MFN insurer essentially controls the price, it can manipulate prices up or down.

But why would the MFN insurer, as a rational buyer, want to raise the price it is willing to pay its medical providers? The answer is the realization of an overall

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<sup>34</sup>Celnicker, *supra* note 2, at 880.

<sup>35</sup>*Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922, 931 (1st Cir. 1984), *cert. den.*, 471 U.S. 1029, 105 S. Ct. 2040, 85 L.Ed.2d 322.

<sup>36</sup>*Ocean State Physicians Health Plan v. Blue Cross and Blue Shield of R. I.*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027, 110 S. Ct. 1473, 108 L.Ed.2d 610 (1990).

<sup>37</sup>Stenger, *supra* note 31, at 115.

increase in net earnings for the insurer. The MFN insurer can increase its net earnings by raising the price it pays to medical providers, and correspondingly the proportional rate it charges its subscribers while maintaining (rather than increasing) its profit margin and maintaining (rather than reducing) its operational efficiency. Because increasing profit margins may be negatively perceived by consumers, and reducing operational efficiency may be negatively perceived by shareholders, the MFN insurer strikes the best balance of increasing its net profits while avoiding both market pitfalls.

First, from an accounting perspective, when an expense (i.e., a liability) is increased, a corresponding increase in an asset must occur to balance the books. If the MFN insurer increases its expenses by raising the price it pays medical providers for their services, it is at least plausible that it will correspondingly raise a particular asset, namely its enrollment subscription revenue, to balance the books. This anticompetitive purpose harms its own enrollees, as well as its competitor's enrollees, by unnecessarily raising prices in the absence of competition. This in itself, however, does not explain the reason the rational buyer wants to raise the price paid to medical providers and raise the cost charged to its subscribers. Why, then, is this behavior rational for the MFN buyer? First, the increase in gross revenue generates an increase in net revenue without raising marginal profit. The percentage of marginal profits remains the same, but the net effect can be a substantial increase in net profits that could largely go undetected by the industry and the courts as anticompetitive in nature.

For example, if an insurer currently has one billion dollars in gross revenue, with a twenty-five percent profit margin, the insurer has two hundred fifty million in net profits. If the insurer increases its expenses paid to medical providers by just one percent, and correspondingly increases its subscriber enrollment fees by just one percent, the new gross revenue is one billion, ten million. If the same twenty-five percent profit margin is maintained, the new net profit is two hundred fifty-two million, five hundred thousand, an increase of two and a half million in net profit. A one percent increase in pricing, even if detected, would not typically be viewed as having an anticompetitive purpose or effect on the market. As such, the MFN insurer raises the price paid to medical providers which justifies raising the cost paid by its subscribers. All the while, the subscribers are completely unaware that their MFN insurer controlled the price and orchestrated an unnecessary two and a half million dollar increase in health care costs to its subscribers. Moreover, the increase in price paid by the MFN buyer may in effect raise the floor of the price paid by other buyers in the market causing a ripple effect of unnecessarily raising consumer prices in the whole market. Therefore, the MFN buyer can effectively manipulate the price floor by unnecessarily raising prices, which has the anticompetitive effect of artificially increasing prices to consumers without any material change in products or services.

Furthermore, this anticompetitive conduct can have a ripple effect on the entire industry. A medical provider must raise the price at which it sells its services to all other non-favored buyers to at least the same price paid to the favored insurer or violate the MFN clause. The additional, more far-reaching anticompetitive effect is an unnecessary price increase to the entire market without any material change in products or services. The severe anticompetitive effects of an unnecessary price increase of even one percent on the entire health care industry without any material benefit to consumers is an unreasonable restraint on trade. Therefore, the real

perversity of the MFN clause is the creation of an appearance of “rising health care costs” across the entire industry, where the MFN clause coercively operates to unnecessarily raise prices by even one percent.

Second, if the MFN insurer opted to raise the price charged to its subscribers without raising the price paid to medical providers (an expense) as described above, then it would have to raise a different expense to make the books balance. Expenses include direct expenses and indirect expenses. While direct expenses include medical provider expenses, for our purposes, indirect expenses generally include administrative overhead expenses. The MFN insurer could raise solely their indirect expenses rather than passing the price increase to the medical provider. If the administrative overhead for this insurer already sits near the top of the range when compared to other insurers, then the MFN insurer has a huge disincentive to categorize the expense as administrative overhead because they already appear economically inefficient relative to their competitors. Even if the MFN insurer’s administrative overhead is in the mid-range, an increase in indirect overhead expenses may indicate operational inefficiency to shareholders. Because higher administrative overhead generally indicates economic inefficiency in delivering insurance to its subscribers and value to its stockholders, the stock’s market value could decline. Therefore, the MFN insurer is more likely to raise the price it pays medical providers than increase administrative overhead to avoid the public perception of being economically inefficient.

## 2. Price Certainty

The medical provider, as a profit-maximizing seller, might willingly embrace an MFN clause with the anticompetitive purpose that restrains their own freedom to discount to MFN rivals and establishes price certainty.<sup>38</sup> The direct effect of discounting to rivals would be to reduce the medical provider’s profits, unless the lower prices attracted a sufficient number of new customers to offset the reduced revenues caused by the lowering of the MFN insurer’s price.<sup>39</sup> The medical provider, albeit in a perverse manner of negotiation, can now say to all market rivals that he is unable to extend a discount because of the MFN agreement. In effect, the medical provider essentially locks-in the lowest price at which he is willing to sell his services, thereby establishing price certainty in the market. It follows that price uncertainty, which can destabilize oligopolistic pricing, is reduced by implementation of an MFN clause.<sup>40</sup> Therefore, if the MFN clause operates to create an artificial price floor with the purpose of establishing price certainty, and the effect is an increase in price to consumers, then the anticompetitive nature of the clause unreasonably restrains trade to the detriment of consumers.

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<sup>38</sup>See *In re Ethyl Corp.*, 101 F.T.C. 425 (1983), *rev’d sub nom.* *E.I. Du Pont de Nemours & Co. v. FTC*, 729 F.2d 28 (2d Cir. 1984). Oligopolistic pricing would be stabilized by an MFN clause. The manufacturer can justify rejecting a request for discount based on the requirement that it would have to extend the discount to all of its customers. See also *United States v. Vision Serv. Plan*, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996).

<sup>39</sup>Celnicker, *supra* note 2, at 866. See *United States v. Vision Serv. Plan*, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996).

<sup>40</sup>Celnicker, *supra* note 2, at 866. (Analyzing FTC’s argument *In re Ethyl Corp.*, the Second Circuit reversed against FTC on grounds of insufficient evidence).

*D. Quadrant IV: Anticompetitive Effects*

MFN clauses may “eliminate a dynamic mechanism by which prices are ratcheted down to the competitive level, reduce [output of medical services], and prevent the market from rewarding more efficient distribution systems.”<sup>41</sup> Anticompetitive effects may include: horizontal price-fixing, unreasonable restraints on vertical trade, elimination of price discrimination, preempting a genuine market floor price, deterrence of new market entrants, elimination or crippling of existing smaller insurers, preventing development of lower-cost plans, depriving the market of innovative and alternative service delivery models, and depriving consumers of differentiated products.

1. Horizontal Price-fixing

Using an MFN clause within one industry raises the possibility of a Sherman Act Section 1 violation for horizontal price-fixing because consumers are deprived of the benefits of price competition.<sup>42</sup> Prices are fixed when they are agreed upon. Thus, any agreement to pay or charge rigid, uniform prices constitutes an unlawful price-fixing agreement under Section 1 of the Sherman Act.<sup>43</sup> Furthermore, price-sharing may be viewed by the Antitrust Division as circumstantial evidence of price-fixing.<sup>44</sup>

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<sup>41</sup>Celnicker, *supra* note 2, at 884.

<sup>42</sup>Stenger, *supra* note 31, at 114-15.

<sup>43</sup>15 U.S.C.A. § 1. *See* United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 84 L.Ed. 1129, 60 S. Ct. 811, *reh. den.*, 310 U.S. 658, 84 L.Ed. 1421, 60 S. Ct. 1091; *see also* 54 AM. JUR. 2d § 71. “Since any interference with the setting of prices by free market forces is unlawful, conspirators do not have to adopt rigid prices in order to be guilty of price fixing. Rather, a combination to maintain prices is nonetheless a violation of the Act even though the prices are not fixed in the sense that they are uniform and inflexible, if the range within which purchases or sales will be made is agreed upon, if the prices paid or charged are to be at a certain level or on ascending or descending scales, if they are to be uniform, or, if by various formulae, they are related to the market prices. Thus, price fixing encompasses any agreement to raise or lower prices, as well as any agreement which creates potential power for price maintenance exhibited by its actual exertion for that purpose. Stabilizing prices as well as raising them is within the ban of Section 1, because in terms of market operations, stabilization is but one form of manipulation. Pursuant to Section 1, therefore, a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate commerce is illegal per se, whatever machinery is employed by the combination to achieve such a result.”

<sup>44</sup>Kip Sturgis, Esq., N.C. Dep’t of Justice Antitrust Division, Health Care Antitrust Seminar guest lecturer discussed the evidentiary use of price-sharing. March 18 (2003). *See* United States v. Delta Dental Plan of Ariz., 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995) (Under a U.S. Consent Decree, Delta Dental of Arizona is enjoined from “[e]xamining, auditing, or monitoring the fees a dentist charges to any other dental plan or to any person other than a Delta Dental Plan participant [and from] [s]ending written communication to dentists regarding the fees dentists charge to persons or dental plans other than Defendant’s.” *See also* United States v. Vision Serv. Plan, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996). Defendant is similarly enjoined from monitoring and auditing fees doctor’s charge other providers.

## 2. Unreasonably Restrains Vertical Trade

While inter-market MFN clauses, regulated by the government, promote competition and free markets, intra-market use of MFN clauses, coerced by market buyers, defeat competition and restrain trade.<sup>45</sup> Typically, only an insurer with sufficient market power can secure an MFN agreement.<sup>46</sup> During negotiations, an insurer with sufficient market power can threaten to take its business elsewhere unless the medical provider agrees to the MFN clause.

Under economic theory, the medical provider, called the rational seller, naturally wants to maximize patient volume and revenue and avoid losing his largest customer. As a result, the rational seller frequently succumbs to the threat and signs the agreement including the MFN clause. The medical provider must then decline all agreements with all other insurers at lower prices than the MFN contract price, lest the provider suffer the penalty of a fee reduction from the MFN insurer. The smaller insurers, therefore, are effectively blocked from competing on price against the MFN insurer who already has sufficient market power. Regardless of whether the smaller insurer operates with greater economic efficiency or is willing to earn a smaller marginal profit, the smaller insurer faces an insurmountable barrier to competition. The MFN contract clause establishes an artificial price floor under which the smaller provider cannot venture to compete.<sup>47</sup> The smaller insurer can neither gain market share through lowering its price, nor benefit from economic efficiency in its operations or innovation in restructuring its enrollees' health plans.

As a case in point, Delta Dental argued that it did not engage in horizontal price-fixing stating its "MFN clause does not prohibit participating dentists from charging lower or higher prices to non-Delta subscribers."<sup>48</sup> The government, however, attacked the MFN clause not for its anticompetitive purpose through horizontal price-fixing, but rather for its anticompetitive effect through vertically restraining trade.<sup>49</sup> The government alleged that the MFN clause's anticompetitive effects, "magnified by Delta's market power, have been to freeze out reduced fee plans from the market, prevent existing plans from offering lower fee options, and, as a result, keep prices *higher* than would be without the clause."<sup>50</sup>

The anticompetitive effect of the MFN clause operates to erect a wall against free trade.<sup>51</sup>

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<sup>45</sup>Stenger, *supra* note 31, at 111-113.

<sup>46</sup>Dennis, Potential Anticompetitive Effects, *supra* note 32, at 72.

<sup>47</sup>See Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, United States Department of Justice, to Cynthia M. Maleski, Commissioner, Pennsylvania Department of Insurance (Sept. 7, 1993) (on file with Anthony J. Dennis).

<sup>48</sup>United States v. Delta Dental of R. I., 943 F. Supp. 172 (D. R.I. 1996).

<sup>49</sup>*Id.*

<sup>50</sup>*Id.* at 191.

<sup>51</sup>15 U.S.C.A § 1. Vertical agreements on resale prices are illegal per se under Section 1 of the Sherman Act. See 54 AM. JUR. 2d § 77. Application of the rule applies regardless of whether the agreements involve the setting of minimum or maximum prices or whether they are written or can be implied from a course of dealing or other circumstances.

Rather than breaking down trade barriers, as evidenced in the history of international trade, intra-market use of MFN clauses in the health care industry have the deleterious effect of creating barriers to free trade.<sup>52</sup> Therefore, MFN clauses unreasonably restrain vertical trading in the health care market and have the negative effects of depriving the market of lower prices, increased operational efficiencies, product differentiation, and service delivery innovation.

### 3. Elimination of Price Discrimination

Why would a medical provider discriminate in price against the dominant insurer by offering a lower price to a small competitor if the MFN clause did not forbid it? The answer lies in basic economic principles underlying the interplay between operational capacity and profitability. A rational seller, the medical provider, would discriminate against its largest buyer and not offer it the best price absent the MFN clause. If a medical provider is working at full capacity serving the dominant insurer, the medical provider has nothing to gain by lowering its price and, therefore, would not price discriminate.<sup>53</sup> If, however, the medical provider has excess capacity, the provider can increase its profits by serving additional patients at a lower price so long as that price exceeds its marginal opportunity cost.<sup>54</sup>

Whenever the dominant insurer fails to supply enough patients to the medical provider to achieve one hundred percent of its operational capacity, the medical provider increases its overall profitability by selling any of its excess capacity at any price that exceeds its marginal cost. The medical provider functions as a rational seller by engaging in price discrimination against its largest supplier when it merely offers a lower price to smaller competitors to fill its excess capacity. The MFN clause, however, coercively operates to prevent the medical provider from maximizing its profitability by selling its excess capacity at a lower price. Furthermore, it restrains new market entrants or smaller existing competitors from soaking up the excess capacity at a bargain price and passing the savings on to its subscribers. The MFN clause undermines the operation of free markets by preventing rational sellers from selling their excess capacity to market competitors who are willing to purchase the excess capacity at discounted rates and pass the savings on to consumers.<sup>55</sup>

Price discrimination, in effect, promotes competition in the marketplace through establishing pricing equilibrium. In a competitive market, absent restraints on price

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<sup>52</sup>See Stenger, *supra* note 31, at 113.

<sup>53</sup>Celnicker, *supra* note 2, at 880.

<sup>54</sup>*Id.*

<sup>55</sup>See *United States v. Delta Dental Plan of Ariz.*, 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995). Under a U.S. Consent Decree, Delta Dental of Arizona is enjoined from “[t]aking any other action, directly or indirectly, to coerce any dentist to refrain from offering discount fees to any person or dental plan within the State of Arizona or to refrain from participating in any dental plan, or to discourage any dentist from offering discount fees or participating in any dental plan.” See also *United States v. Vision Serv. Plan*, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996). Defendant is similarly enjoined and restrained from taking any action to discourage doctors from participating in rival plans and offering or charging lower fees to rival plans.

induced through MFN clauses, the price that excess capacity is sold at establishes the genuine price floor for medical services. The excess capacity price in a free market, therefore, is the lowest price at which the seller is willing or able to sell his medical services. Because the MFN clause operates to prevent an otherwise free market from establishing a lower price paid by smaller insurance competitors, and ultimately lower prices paid by consumers, the MFN clause unreasonably restrains trade in the market as a whole with detrimental effects on the price to consumers.

As a result, the dominant insurer controls market supply by preventing discounted sell-off of excess capacity. The MFN clause operates to prevent price discrimination and control output (supply)<sup>56</sup> by putting a choke-hold on the natural dynamic of the market where excess capacity is ordinarily sold at a cheaper price to competitors.<sup>57</sup> In effect, the MFN clause prevents a natural lowering of prices that otherwise occurs in a competitive market.

#### 4. Preempts a Genuine Market Floor Price

The perception that the dominant insurer in the market should always receive the lowest price in exchange for the large volume of business it extends is a fallacy. From an economic perspective, price is tied to the relative elasticity of demand for services. For example, traditional BCBS plans frequently enjoy sufficient market power, generally are open to dealing with all providers, and contract with a large percentage of all medical providers in their markets to serve their subscribers.<sup>58</sup> In contrast, a relatively small HMO or PPO adequately serves its subscribers with relatively few providers.<sup>59</sup> An insurer demanding coverage for a larger volume of business has less elasticity in making purchasing decisions based on price because it is confounded by its commitment to provide access to medical care for a large volume of patients. Conversely, an insurer demanding coverage for a relatively small volume of business has more elasticity in making purchasing decisions based on price because its commitment to provide care through a closed panel of a few physicians allows it to move its business to obtain the best price.<sup>60</sup>

The small insurer can select only those providers who have excess capacity and are willing to discount their fees to maximize their efficiency and profitability.<sup>61</sup> In contrast, the largest insurer is at a disadvantage in securing the lowest price in the

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<sup>56</sup>Celnicker, *supra* note 2, at 884.

<sup>57</sup>While the MFN clause's control over excess capacity or total volume of output may appear to have the benign or even desirable effect of indirectly controlling utilization of medical services of existing subscribers, a much greater deleterious effect may result. If the excess capacity or output were not restrained by the clause, this output could, at least theoretically, be used to create a low-cost/low-benefit option for some currently uninsured consumers. Kip Sturgis, Esq., N.C. Dep't of Justice Antitrust Division, Health Care Antitrust Seminar guest lecturer on March 18, 2003, concurred in the merits of this argument and the potential anticompetitive effect.

<sup>58</sup>Celnicker, *supra* note 2, at 882.

<sup>59</sup>*Id.*

<sup>60</sup>*Id.*

<sup>61</sup>*Id.*

free market because it is not typically negotiating contracts for excess capacity where the rational seller is more willing to discount price to marginally increase productivity and profitability. Smaller buyers with relatively elastic demand are more sensitive to price, and in response to price fluctuations, will change their buying decisions to a greater degree than larger buyers with relatively inelastic demand.<sup>62</sup>

As a result, the larger buyer with relatively inelastic demand, who has less overall flexibility in meeting its contractual commitment to provide access to medical services to its larger volume of subscribers, is less capable of responding to higher prices by shifting its business to other sellers. In a free market, price discrimination operates on relative elasticity in demand as well as excess capacity. Therefore, medical providers acting as rational sellers, who possess excess capacity, have a strong incentive to maximize their profitability by offering discounts on a small portion of their business to maximize efficiency by selling to a subgroup of buyers in a market whose subscribers desire the lower price in exchange for a limited choice between medical providers. The large insurer, however, may perceive that such adverse price discrimination places it at a competitive disadvantage which stimulates its desire to employ a device, the MFN clause, to defeat price competition.<sup>63</sup>

### 5. Deters New Market Entrants

“Normally the choice of what to seek and buy and what to offer to pay is the buyer’s.”<sup>64</sup> As one of the first courts to consider the potential anticompetitive effects of MFN clauses, the *Reazin* court, explored how the clause operated as a disincentive for medical providers to discount price to smaller competitors.<sup>65</sup> If the medical provider cannot balance the discount offered to the non-favored competitor with enough volume to offset the effects of the large volume of the favored insurer’s corresponding reduction in price, then the medical provider will not offer a discount to the smaller competitor.<sup>66</sup> Therefore, the disincentive to discount, in effect, makes market entry by new competitors more difficult because new entrants are restrained from competing with price discounts to gain market share.

Moreover, the classic behavior of new market entrants includes a willingness to lower prices to gain market share.<sup>67</sup> The MFN insurer as a rational buyer, who possesses dominant market power, may not need to lower its price to the lowest level to maintain or even increase its market share because it enjoys other benefits of market power including efficiencies achieved through economies of scale, brand recognition, and the stability of consumer habits. Arguably, as the largest volume insurer, the dominant insurer through economies of scale may pay a marginally

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<sup>62</sup>*Id.*

<sup>63</sup>See *id.*

<sup>64</sup>*Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922, 923, 929 (1st Cir. 1984).

<sup>65</sup>*Reazin v. Blue Cross and Blue Shield of Kan.*, 899 F.2d 951 (10th Cir. 1990), *cert. den.*, 110 S. Ct. 3241 (1990).

<sup>66</sup>*Id.*

<sup>67</sup>Stenger, *supra* note 31, at 115.



higher price to medical providers while still remaining competitive in the ultimate price offered to consumers. The dominant insurer, however, argues that it is entitled to receive the most favorable price because it sends the greatest volume of business to the medical provider. But, the argument is unsupported by the economic effects on competition. Even a relatively higher price paid to the medical provider, does not necessarily render the dominant insurer less competitive to a medical provider or to its subscribers.

First, if the dominant insurer is able to pay a higher price to the medical provider, while maintaining its competitive price ultimately paid by subscribers, then medical providers will be more interested in securing contracts with the dominant insurer. As a rational seller, the medical provider welcomes business which pays him more for similar services. Arguably, the dominant insurer could bargain for value-added products and services because of the higher price it pays. The leverage of the large volume of business and higher relative price paid for a similar service, combined with the medical providers' natural inclination to improve the health status of patients, stimulates a climate where ingenuity creates new products and models for delivering quality care. The value-added services can give the dominant market insurer a remarkable competitive advantage in differentiating its products and services in aspects other than price. Therefore, the use of an MFN clause by the dominant insurer may unreasonably restrain trade because the MFN insurer prevents new insurers from entering the market.

#### 6. Eliminates or Cripples Existing Smaller Competitors

In dictum, the *Delta Dental* Court described the adverse impact on the consumer. The MFN clause causes participating dentists to be unwilling to contract with other plans at reduced fees.<sup>68</sup> The anticompetitive punch felt in the market is that existing competing plans have not expanded into lower price options and new reduced-fee plans have been precluded from entering the market. The *Delta Dental* court found that the net effect was a "detrimental impact on the dental market without any discernable competitive benefits."<sup>69</sup>

#### 7. Prevents Development of Lower-cost Plans

The complaint against Medical Mutual alleged that the insurer unreasonably restrained trade in violation of the Sherman Act Section 1 by requiring hospitals, as sellers, to sign most favored rates (MFR) clauses. Specifically, the United States alleged that this MFR clause "stifled the development of innovative and less costly health plans."<sup>70</sup>

Furthermore, the Report of the Attorney General's National Committee to Study Antitrust Laws concluded that "a seller constrained by law to reduce prices to some

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<sup>68</sup>See *United States v. Vision Serv. Plan*, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996). Competitors have been unable to obtain or retain a sufficient number of optometrists at competitive prices. MFN clause has effectively deprived vision care consumers of the benefits of free and open competition and deprived the uninsured patients of price competition as well.

<sup>69</sup>*United States v. Delta Dental of R. I.*, 943 F. Supp. 172, 192 (D.R.I., 1996).

<sup>70</sup>*United States v. Medical Mut. of Ohio*, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio 1999).

only at the cost of reducing prices to all may well end up reducing them to none.”<sup>71</sup> MFN clauses, in effect, prevent price competition; therefore, MFN clauses are the antithesis of competition as this device operates to inhibit lowering of prices and facilitates tacit collusion.<sup>72</sup> Additionally, an MFN clause places greater limitations on competitive pricing responses and is more likely to lead to price uniformity.<sup>73</sup>

#### 8. Deprives the Market of Innovative and Alternative Service Delivery Models

Blue Cross and Blue Shield’s (BCBS) market power in the health care industry was threatened seriously upon the emergence of HMOs and PPOs.<sup>74</sup> In response to the threat to BCBS’s traditional plans, BCBS launched a counter-attack by requiring its providers to sign MFN clauses. The MFN clauses, in effect, prohibited medical providers from granting and alternative delivery systems from receiving selective discounts.<sup>75</sup> Therefore, if an MFN clause deprives the market of innovative and alternative service delivery models, then the device may erect an unreasonable barrier to trade to the detriment of the market and ultimately consumers.

#### 9. Deprives Consumers of Differentiated Products

The complaint against Medical Mutual alleged that the insurer unreasonably restrained trade in violation of the Sherman Act Section 1 by requiring hospitals, as sellers, to sign most favored rates (MFR) clauses. Specifically, the United States alleged that the MFR clause had an anticompetitive effect on the market and as a result “businesses and consumers paid . . . higher than competitive prices and were deprived of innovative and less costly alternatives for *health care services*.”<sup>76</sup> MFN clauses, therefore, operate to defeat the utilization of excess capacity by smaller insurers to create innovative, lower-cost products which would emerge in an otherwise free market to the benefit of the market and ultimately consumers.

Therefore, the nature and magnitude of the actual anticompetitive purposes and effects caused by the implementation of an MFN clause will be balanced against the pro-competitive purposes and effects under the Sherman Act Section One’s the rule of reason. If, on balance, the anticompetitive purposes and effects outweigh the pro-competitive purposes and effects, then the court should conclude that the MFN device is a contract, combination or conspiracy that operates to unreasonably restrain trade to the detriment of consumers in violation of antitrust law under Section 1 of the Sherman Act.

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<sup>71</sup>Celnicker, *supra* note 2, at 885 & n.137.

<sup>72</sup>*Id.* at 885.

<sup>73</sup>*Id.* at 890.

<sup>74</sup>*Id.* at 869.

<sup>75</sup>*See id.* at 870. *See* United States v. Vision Serv. Plan, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996). MFN clause has had the effect of reducing the scope of vision care coverage alternatives, such as managed care and other discount plans.

<sup>76</sup>United States v. Medical Mut. of Ohio, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio 1999).

### III. DEFEATING THE PRESUMPTIONS OF PRO-COMPETITIVENESS

When the MFN clause was introduced to the health care industry, the device presumptively operated as a pro-competitive means to reduce restraints on trade because of the historical origins of MFN clauses. The historical roots of the MFN clause are found in international trade agreements which have served as a mechanism to guard against protectionist trade barriers.<sup>77</sup> The MFN's concept was designed to reduce trade distortion through the prohibition of protectionist trade barriers, such as tariffs and quotas, which maximize global trade benefits through the creation of relatively free markets.<sup>78</sup> In the historical context, the government, not the buyers and sellers within the market, implemented the MFN clause as a regulatory measure to eliminate protectionist tactics and to promote competition in free markets. Based on principles of reciprocity and nondiscrimination, MFN clauses promote competition in international trade, as well as in the arena of public utilities and multiparty litigation settlements.<sup>79</sup>

Given their legacy, there should be no surprise that courts adopted the presumption that MFN clauses promote competition and reduce trade barriers. The historical significance of the federal government, in its regulatory capacity rather than as a party to the contract, using the MFN clause to promote competition across several market sectors rather than in one specialized industry, distinguishes its historical application from its current use in health care. In the health care industry, an insurer/buyer with sufficient market power, as a party to the contract within a specialized industry, exerts its market power to gain a competitive advantage. Exerting market power to gain a competitive advantage certainly does not, in and of itself violate antitrust law. Rather, efforts to unreasonably restrain trade which have an anticompetitive effect on the whole market may violate antitrust laws.<sup>80</sup> The courts should abandon the historical presumption of pro competition when an MFN clause is employed within one specialized industry by a party to the contract.<sup>81</sup> The actual negative anticompetitive effects against the health care market defeat the historically-based presumption of pro-competitive purposes recognized in international trade. Therefore, the presumption should be abolished in health care cases.

### IV. U.S. CONSENT DECREES

For many years large third party insurers, such as Blue Cross and Blue Shield (BCBS), who used MFN clauses, enjoyed the presumption that the device served pro-competitive purposes. During the 1980's, federal and state courts alike rejected antitrust attacks on MFN clauses.<sup>82</sup> Market competitors who challenged the use of

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<sup>77</sup>Stenger, *supra* note 31, at 111.

<sup>78</sup>*Id.* at 111-12.

<sup>79</sup>*Id.* at 111.

<sup>80</sup>*United States v. Delta Dental of R. I.*, 943 F. Supp. 172 (D.R.I. 1996).

<sup>81</sup>*See* Stenger, *supra* note 31, at 127-28.

<sup>82</sup>*Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I.*, 883 F.2d 1101 (1st Cir. 1989), *cert. den.*, 110 S. Ct. 1473 (1990); *Kitsap Physicians Serv. v.*

the MFN clause alleging anticompetitive purposes or even “potential” anticompetitive effects under the Sherman Act Sections 1 and 2 consistently lost.<sup>83</sup> Similarly, the Federal Trade Commission and the Antitrust Division of the United States Department of Justice were generally unwilling to challenge the use of MFN clauses in the health care industry.<sup>84</sup> Subsequent to several investigations involving MFN clauses in which no action resulted, the head of the Antitrust Division stated in 1988 that it was “unlikely” to challenge MFN clauses between third-party payers and medical providers.<sup>85</sup> The prevailing view for years supported the proposition that MFN clauses are based primarily on the notion that is not only fair for the favored insurer to require a lowering of its price to meet a more favorable price extended to any other insurer, but also leads to lower prices throughout the market.<sup>86</sup> The tide has only recently started to change as substantial evidence of actual negative anticompetitive effects pervade some local markets.

Beginning in 1995, on five separate occasions against four separate insurers, where upon the U.S. Government filed a valid claim against the insurer, pursuant to alleged violations under Section 1 of the Sherman Act, each insurer has agreed to render its MFN clause unenforceable through the terms of a U.S. Consent Decree.<sup>87</sup> *Medical Mutual of Ohio* and *Delta Dental of Rhode Island*, discussed in detail below, exemplify the nature and magnitude of the anticompetitive purposes and effects caused by the MFN clause under the rule of reason analysis.<sup>88</sup>

First, the United States of America filed its complaint alleging violations of the Sherman Act Section 1 in September of 1998, against Medical Mutual.<sup>89</sup> The consent decree<sup>90</sup> enjoins and restrains Medical Mutual from “adopting, maintaining, or enforcing,” a most favored rates (MFR) requirement or any other device having

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*Washington Dental Serv.*, 671 F. Supp. 1267 (W.D. Wash. 1987); *Blue Cross and Blue Shield of Mich. v. Michigan Ass’n of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980); *Madden v. California Dental Serv.*, 1986-1 Trade Cas. (CCH) ¶ 67, 176 (Cal. Super. Ct. 1986).

<sup>83</sup>Celnicker, *supra* note 2, at 864.

<sup>84</sup>*Id.* at 864-65.

<sup>85</sup>*Id.* at 865.

<sup>86</sup>*Id.* at 865.

<sup>87</sup>*See supra* note 22.

<sup>88</sup>*See supra* note 22.

<sup>89</sup>*United States v. Medical Mut. of Ohio*, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio Sept. 30, 1999).

<sup>90</sup>*Id.* “[W]ithout a trial or final adjudication of any issue of fact or law,” the parties entered into a consent decree in January of 1999. The United States, as plaintiff, and Medical Mutual of Ohio, as defendant, entered into U.S. Consent Decree in which Medical Mutual was prohibited from enforcing its most favored rate requirement.”

The prohibited policy requires participating hospitals “to charge any [t]hird [p]arty [p]ayer[s] as much or more than the rate charged to Medical Mutual” or required a participating hospital “to charge *Medical Mutual* rates equal to or lower than the lowest rate it charges any [t]hird [p]arty [p]ayer.”

the “same purpose or effect.”<sup>91</sup> Additionally, the consent decree enjoins and restrains Medical Mutual from “adopting, maintaining or enforcing any policy, practice, or agreement” that requires disclosure, by any means, of the rates that a participating hospital offers or accepts from other insurers, except when coordinating benefits with a specific claim.<sup>92</sup> The effect of the consent decree is to render the MFR requirement null and void, imposing no obligation, on any participating hospital in the Cleveland Region.<sup>93</sup>

A “competitive impact statement,” while not part of the final judgment, is included with the consent decree to “provide the information necessary to enable the Court and the public to evaluate the proposed [f]inal [j]udgment.”<sup>94</sup> The competitive impact statement sets forth the evidence that the government had at the time the parties entered into the consent decree. The competitive impact statement reveals that the complaint against Medical Mutual alleged that the insurer unreasonably restrained trade in violation of Sherman Act Section 1 by requiring hospitals, as sellers, to sign MFR clauses. Specifically, the United States alleged that this MFR clause “had the effect of requiring those hospitals to charge Medical Mutual’s competitors significantly more than they charged Medical Mutual or pay substantial penalties.”<sup>95</sup> Therefore, the Department of Justice felt that the penalties exacted for breaching the MFR agreement in addition to lowering the price to the most favored rate erected an unreasonable barrier to trade.

Second, the United States filed suit against Delta Dental of Rhode Island alleging that the MFN clause in the insurer’s contracts with its dentists violated Section 1 of the Sherman Act. *United States v. Delta Dental of Rhode Island* was heard under a claim for a motion to dismiss for failure to state a claim upon which relief can be granted.<sup>96</sup> Subsequent to the denial of the motion for dismissal, the parties entered into a consent decree. The competitive impact statement alleged facts in evidence regarding the following anticompetitive conduct: exclusion of reduced-cost plans from the market; blocked market entry or expansion of several low-cost plans including withdrawal of such plans from the market; preventing discounted rates that would have significantly reduced or eliminated subscriber co-payments; a contract provision that added a financial penalty in addition to lowering the rate which acted as a deterrent to discounting to uninsured patients; no meaningful savings or other pro-competitive benefits have been realized by Delta subscribers; and, by effectively setting the price floor, Delta has raised the cost of dental services and dental insurance for Rhode Island consumers.<sup>97</sup>

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<sup>91</sup>*Id.*

<sup>92</sup>*Id.*

<sup>93</sup>*Id.*

<sup>94</sup>*Id.* See also Antitrust Procedures and Penalties Act, 15 U.S.C. 16(b)-(h) (2005).

<sup>95</sup>*Id.*

<sup>96</sup>*United States v. Delta Dental of R. I.*, 1997-2 Trade Cas. (CCH) ¶ 71,860 (D. R.I. July 2, 1997).

<sup>97</sup>*Id.*

V. INDICIA OF A MERITORIOUS CLAIM AGAINST AN INSURER EMPLOYING AN MFN  
CLAUSE UNDER SECTION 1 OF THE SHERMAN ACT

As the tide begins to change, indicia of meritorious claims are beginning to emerge which can serve as a guide both to structure the parties and the nature of the claim and to assess the relative merits of the claim. Emerging indicia of a meritorious claim for injunctive relief against an MFN insurer may include: a Sherman Act Section 1 complaint where the rule of reason is applied; an MFN clause which imposes an automatic reduction in price, and sometimes more egregiously imposes a monetary penalty in addition to lowering the price; implementation of the MFN clause by an insurer with sufficient market power; de facto intra-market use of the MFN clause; an anticompetitive injury in fact which is causally related to the MFN clause; and, an action brought by a plaintiff who is not party to the MFN contract.

A. *Claims Brought Under the Sherman Act Section 1*

Sherman Act Section 1 states that “[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.”<sup>98</sup> Because any agreement concerning trade can restrain competition, the Supreme Court has interpreted Section 1 to “render unlawful only those restraints of trade that unreasonably restrict competition.”<sup>99</sup> The Section 1 claim, as opposed to a Section 2 claim, captures the essence of how the MFN clause operates.<sup>100</sup> The MFN clause is typically part of a contract, combination, or conspiracy which unreasonably restrains trade when the anticompetitive purposes and effects outweigh the pro-competitive purposes and effects under the rule of reason.

B. *MFN Clause-automatic Reduction in Price, and Monetary Penalty in Addition to Lowering Price*

Medical Mutual’s MFR clause compelled any non-governmental insurer with a “lower total dollar volume” to pay rates equal to or higher than Medical Mutual.<sup>101</sup> Additionally, the agreement required hospitals to maintain a 15-30% differential between the rates charged to Medical Mutual and all other smaller commercial insurers.<sup>102</sup> This percentage differential created a significant cost advantage over its competitors purchasing hospital services.<sup>103</sup>

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<sup>98</sup>See the Sherman Act, 15 U.S.C. § 1.

<sup>99</sup>United States v. Delta Dental of R. I., 943 F. Supp. 172 (D. R.I. 1996).

<sup>100</sup>See Sherman Act, 15 U.S.C. § 2.

<sup>101</sup>United States v. Medical Mut. of Ohio, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio Sept. 30, 1998).

<sup>102</sup>*Id.*

<sup>103</sup>Dennis, *Potential Anticompetitive Effects*, *supra* note 32, at \*80. “MFN contract clauses can establish a price floor with respect to the overall cost of all health insurance products offered in that market. A health plan’s overall expenses determine in large part the price it will charge for all of its health insurance products. The cost of delivering medical care constitutes most of a health plan’s costs in offering health insurance products. If an MFN

Medical Mutual enforced its MFR clause and percentage differential provision with the express dual “purpose of protecting it against competition and significantly raising its competitor’s hospital costs.”<sup>104</sup> A hospital’s violation of the percentage differential provision had devastating financial effects which exacted huge penalties.<sup>105</sup> A hospital who failed to maintain the percentage differential even when the breach occurred as result of a discount awarded to a competitor for case mix or utilization management paid the penalty.<sup>106</sup> For example, Medical Mutual assessed a penalty of \$342,916 against a participating hospital for giving a competitor a discount below Medical Mutual totaling \$13,831.<sup>107</sup> The increased costs of hospital services to other insurers and consumers harmed competition in the health care market as opposed to harming one or two competitors.<sup>108</sup>

The complaint also alleged that Medical Mutual’s MFR clause and percentage differential rate caused competitors to enter complicated and costly contractual arrangements, called “stop-loss” provisions, to avoid triggering the MFR penalties.<sup>109</sup> The U.S. Government contended that these additional costs were borne by competitors and ultimately consumers. Therefore, an especially egregious MFR clause which exacts a monetary penalty in addition to lowering prices to the most favored rate raises red flags as an onerous restraint on trade.

### *C. Sufficient Market Power*

The head of the Antitrust Division in 1988 stated that when the insurer controls at least thirty-five percent of the business in the relevant market further analysis is warranted.<sup>110</sup> In assessing the competitive effects, the Division will inquire whether the imposed clause was motivated by factors other than the desire to get the best price possible and whether there is sufficient excess capacity for new insurers to enter the market.<sup>111</sup>

Earlier cases failed to account for the significance of an insurer with sufficient market power using the MFN clause to defeat competition. A closer look, however, reveals that earlier holdings reflect an insufficiency of evidence, particularly

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clause sets a price floor for a particular type of medical service, then it also indirectly operates to establish a price floor with respect to the ultimate price of all products . . . [T]he largest single expense item for any health plan is typically hospital costs.”

<sup>104</sup>United States v. Medical Mut. of Ohio, No. 1:98 CV2172, 1999 WL 670717, at \*6 (N.D. Ohio Jan. 29, 1999).

<sup>105</sup>*Id.*

<sup>106</sup>*Id.*

<sup>107</sup>*Id.*

<sup>108</sup>*Id.* Many hospital systems including MetroHealth, the Cleveland Clinic, University, Meridia, Lake, Marymount, Southwest General, Mt. Sinai, and Fairview were all deterred from offering discounts up to 20% or more to Medical Mutual’s competitors, and ultimately to their enrollees.

<sup>109</sup>*Id.*

<sup>110</sup>Celnicker, *supra* note 2, at 865.

<sup>111</sup>*Id.*

evidence of actual anticompetitive effects, rather than dismissal of market power as a relevant factor under Section 1 analysis. *Kartell* is one such example of insufficient evidence of anticompetitive effects. After declaring that Blue Shield was merely acting as a rational buyer, the First Circuit, in the *Kartell* case, stated the general antitrust principle that the “law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold.”<sup>112</sup> Even if Blue Shield possessed sufficient market power and used that power to obtain lower than competitive prices, the “antitrust laws interfere with a firm’s freedom to set even uncompetitive prices only in special circumstances,” that is, where the price is predatory (below incremental cost).<sup>113</sup>

More recent cases, in contrast, give credence to the effect market power can have on competition. Under the rule of reason analysis, the *Delta Dental* court considered “significant market power” as one factor in balancing the effects on competition.<sup>114</sup> Armed with significant market power, a plausible allegation is made, that “*Delta* applies its MFN [clause] selectively to block alternative reduced-fee plans from the dental insurance market, but has discerned no discernable cost savings.” Furthermore, the government alleged that the “practice has sustained or increased consumer dental costs in the form of premiums” without any perceived competitive benefits.<sup>115</sup>

#### *D. Intra-market Use of the MFN Clause*

Use of the MFN clause in the health care industry is de facto intra-market use of the device. As the historical origins of MFN clauses show, the device is pro-competitive when implemented by the government, a non-party to the contract, to reduce existing trade barriers.<sup>116</sup> MFN clauses, even absent allegations of predatory pricing, “discourage discounting, facilitate oligopolistic pricing, and deter entry or expansion by more efficient distribution systems” when implemented within one market sector.<sup>117</sup> The historical basis underlying the presumption of the pro-competitive nature of MFN clauses quickly erodes when one distinguishes its current use in health care from its historical origins. Therefore, when the MFN clause is implemented by the parties to the contract, combination, or conspiracy, within one specialized industry such as health care, where no existing trade barrier is present, the historical presumption of pro-competitive purposes and effects crumbles.

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<sup>112</sup>*Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922, 925 (1st Cir. 1984).

<sup>113</sup>*Id.* at 927.

<sup>114</sup>*United States v. Delta Dental of R.I.*, 943 F. Supp. 172, 190 (D. R.I. 1996).

<sup>115</sup>*Id.*

<sup>116</sup>See *supra* Part III, Defeating the Presumption of Pro-competitiveness, and *supra* text accompanying notes 77-81.

<sup>117</sup>Celnicker, *supra* note 2, at 891.



*E. Anticompetitive Injury in Fact Which is Causally Related to the MFN Clause*

The injury must have an anticompetitive effect on the health care market rather than one or two competitors.<sup>118</sup> (Anticompetitive injury to market competitors ultimately causing higher health care costs, fewer choices among providers and reduced access to medical services that unreasonably harms subscribers).

The best evidence shows that by comparison of the market's status either prior to or in isolated cases after the MFN clause was rendered unenforceable, the MFN competitors paid lower rates to medical providers, consumers had lower health care costs, more choices among providers, and greater access to medical services.<sup>119</sup> For example, in cases where Medical Mutual's MFR clause was inapplicable under the terms of the agreement, the hospitals willingly offered lower rates to Medical Mutual's competitors.<sup>120</sup> Such examples highlight the "but for" causal link between the MFR clause and its restraint on price competition which harms consumers.

*F. Party Posture*

Any Sherman Act Section 1 claim is less likely to succeed if brought by a party to the contract, combination or conspiracy. Actions brought by competing insurers, subscribers, or the U.S. Department of Justice Antitrust Division are more likely to succeed under a Section 1 claim.

Although *Kartell v. Blue Shield of Massachusetts* involves a ban on balance billing provision, as opposed to an MFN clause, the case is instructive regarding party posture when bringing a Sherman Act Section 1 claim. In *Kartell v. Blue Shield of Massachusetts*, the Kartell physicians were party to the Blue Shield contract.<sup>121</sup> Here, the Kartell physicians sued Blue Shield under Section 1 of the Sherman Act alleging that the ban on balance billing practice unreasonably restrained trade. A ban on balance billing agreement requires the physicians to forego additional charges to subscribers in return for direct payment. The same physicians who voluntarily contracted with Blue Shield to refrain from billing any additional payments to subscribers brought suit against Blue Shield.

Section 1 requires "a contract, combination, or conspiracy" to restrain trade. Because Kartell is party to the contract which allegedly restrained trade, and introduced no supportable evidence of any other contract, combination, or conspiracy, to the allegedly unlawful method used to restrain trade, Kartell cannot win under traditional Section 1 analysis. Either Kartell participated in an unlawful contract to restrain trade by agreeing to the ban on balance billing, or Kartell lacked an essential element of proving the Section 1 claim for want of a "contract, combination, or conspiracy." Therefore, the identity of the adverse parties to this lawsuit, who are the same parties on opposite sides of the contractual agreement, precludes the physicians from proving the existence of "a contract, combination, or

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<sup>118</sup>*Delta Dental*, 943 F. Supp. at 186 (citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 319-20, 82 S. Ct. 1502, 1521, 8 L.Ed.2d 510 (1962)).

<sup>119</sup>*United States v. Medical Mut. of Ohio*, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio, E. Div.).

<sup>120</sup>*Id.*

<sup>121</sup>*Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922 (1st Cir. 1984).

conspiracy” that places an unreasonable restraint on trade without simultaneously proving their own illegal conduct.

The party posture in *Kartell*, therefore, demands “unilateral activity” by Blue Shield.<sup>122</sup> As such, the First Circuit articulated an alternative premise on which the physicians, as a party to the contract with the billing provision which allegedly restrained trade, could prevail under a Sherman Act Section 1 claim. The First Circuit reasoned that to find an unlawful restraint on trade, Blue Shield would have to be viewed as a “third force” intervening in the marketplace to prevent willing buyers and sellers from coming together to strike a bargain based upon price and quality.<sup>123</sup> Antitrust law “frowns upon behavior” that erects a barrier to otherwise independent bargains.<sup>124</sup> If, as the district court posits, the medical provider is the seller and the subscriber is the buyer, then Blue Shield can be viewed as the third force. The First Circuit concluded, however, that Blue Shield was not an inhibitory “third force,” rather Blue Shield operated as the purchaser of services.<sup>125</sup> Blue Shield, as a commercial insurance purchaser, essentially “buys medical services for the account of others.”<sup>126</sup> Therefore, even under the third force theory, the antitrust plaintiff still fails to satisfy an element of the cause of action when the antitrust defendant is perceived as the buyer rather than a third force in the market.

In contrast, *Delta Dental* was brought by the United States Department of Justice Antitrust Division. *Delta Dental* teaches that an insurer who contends his activity is “merely unilateral” when each participating dentist accepts Delta’s terms in adopting the prudent buyer clause can be defeated by the express agreement itself.<sup>127</sup> “Although the Supreme Court has recognized that Section 1 does not reach conduct that is ‘wholly unilateral,’<sup>128</sup> concerted action may be amply demonstrated by an express agreement.”<sup>129</sup> Each dentist explicitly agreed to comply with Delta Dental’s agreement, including the prudent buyer clause. The court concluded that the requisite concerted action to satisfy the element of conspiracy between two parties was clearly alleged to defeat the motion for dismissal.<sup>130</sup> Clearly, the district court’s analysis should concern *any medical provider*, in addition to any insurer, who participates through a contract, combination, or conspiracy to implement an MFN clause. Both parties to the contract, as opposed to only the MFN insurer, may be charged with unlawfully restraining trade in violation of antitrust law.<sup>131</sup> Therefore,

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<sup>122</sup>*Id.*

<sup>123</sup>*Id.*

<sup>124</sup>*Id.*

<sup>125</sup>*Id.*

<sup>126</sup>*Id.*

<sup>127</sup>United States v. Delta Dental of R. I., 943 F. Supp. 172, 185 (D. R.I. 1996).

<sup>128</sup>*Id.* (citing *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 767-68, (1984)).

<sup>129</sup>*Id.* (citing *Addyston Pipe & Steel Co. v. United States*, 175 U.S. 211, 213-18, (1899)).

<sup>130</sup>*Id.*

acquiescence in an illegal scheme is as much a violation of the Sherman Act<sup>132</sup> as the creation or promotion of one.<sup>133</sup>

Furthermore, any medical provider who brings a Section 1 claim and prevails must be concerned whether the antitrust defendant will then refuse payment for any outstanding amounts of money owed to the medical provider under a contract which is declared illegal by the court. On the one hand, the Supreme Court has said that where there has been a sale of goods at a contract price, payment cannot be avoided on the plea that the transaction was part of a plan to violate the Sherman Act.<sup>134</sup> On the other hand, where enforcement of a contract by the court would involve effectuating conduct that is unlawful under the antitrust laws, enforcement will be denied.<sup>135</sup> Therefore, the medical provider, as a party to the MFN contract, who prevails on judgment rendering the clause an unlawful restraint on trade, at least risks losing any outstanding payments due for services performed under the unlawful contract.

## VI. CONCLUSION

The U.S. Government, corporations offering employer-based health insurance, and American citizens as consumers of health care all have reason for serious concern regarding the anticompetitive nature of MFN clauses. These clauses have the effect of unnecessarily raising consumer costs for health insurance, reducing choice among providers, constraining access to care, and preventing the development of alternative health care delivery models. Three recommendations emerge based upon the current use and anticompetitive effects of MFN clauses in the health care market.

First, the antitrust plaintiff, who brings an action alleging Sherman Act Section 1 violations, can evaluate the merits of his claim in light of his factual evidence of pro-competitive purposes and effects versus anticompetitive purposes and effects as analyzed in this paper. Second, the courts should abolish the presumption of the pro-competitive nature of MFN clauses in health care because the historical origins which created the pro-competitive presumption bear no resemblance to their current application in health care. Third, the U.S. Department of Justice Antitrust Division should litigate at least one Sherman Act Section 1 claim involving an MFN clause to establish precedent that, at least in some cases, MFN clauses may unlawfully restrain trade. Fourth, the antitrust plaintiff can review the indicia of a meritorious claim

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<sup>131</sup>See *United States v. Lykes Bros. Steamship Co., Inc.*, 1996-1 Trade Cas. (CCH) ¶ 71,272 at 76,193. The U.S. Justice Department challenged the seller rather than the purchaser to the MFN agreement. See also Anthony Dennis, "Best Price" Clauses in Health Care Provider Contracts: An Antitrust Critique, 3 Conn. Ins. L.J. 79, 91-98 (1996) (summary analysis of Lykes Bros.).

<sup>132</sup>15 USCA §§ 1-7. See 54 Am. Jur. 2d. § 42, Acquiescence in Illegal Scheme.

<sup>133</sup>*United States v. Paramount Pictures, Inc.*, 334 U.S. 131, 92 Led. 1260, 68 S. Ct. 915, 77 USPQ 243.

<sup>134</sup>24 AM. JUR. *Trials* 1, § 22 (2002). See *Kelly v. Kosuga*, 358 U.S. 516, 3 L.Ed.2d. 475, 79 S. Ct. 429, *reh. den.*, 359 U.S. 962, 3 L.Ed.2d. 769, 79 S. Ct. 796.

<sup>135</sup>24 AM. JUR. *Trials* 1, § 22 (2002). *Continental Wall Paper Co. v. Louis Voight & Sons Co.*, 212 U.S. 227 (1909).

defined in this paper as a benchmark assessment of the relative strength of their claim compared to those in which MFN insurers entered U.S. Consent Decrees rendering their MFN clause null and void.